



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

DR AHMED KHALIFA  
1415 SOUTH HWY 6 SUITE 400D  
SUGARLAND TX 77478

#### **Respondent Name**

AMERICAN HOME ASSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-0470-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "I am in receipt of the attached E.O.B. related to the date of service August 05, 2010. Based on this E.O.B. the medical bill of \$138.41 for the procedural code 99214 was reduced to \$117.65. The rationale for the denial was 'this charge was reviewed in accordance with your contract'." "Please note that Dr. Ahmed Khalifa...never had a contract with Beech Street/Focus."

**Amount in Dispute:** \$20.76

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary dated November 1, 2010:** "The billed amount of \$138.41 was paid at \$117.65 per a PPO contract as Dr. Rabbani states. Dr. Rabbani maintains that no contract existed on the date of service, and in fact has filed suit regarding this issue." "I am attempting to determine if this date of service is or is not covered by a PPO contract. If it is not, the carrier will make full payment to Dr. Khalifa. If it is covered by a PPO contract, this contract will be furnished to you by Focus Beech Street."

**Respondent's Supplemental Position Summary dated November 2, 2011:** "Dr. Khalifa was able to prove that the PPO contract was not valid for this date of service. The carrier has paid \$117.65 and the Explanation of Review showing the payment is attached. This should conclude this dispute."

**Response Submitted by:** Chartis, 4100 Alpha Road, Suite 700, Dallas, TX 75244

### ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2010	Office Visit – CPT Code 99214	\$20.76	\$20.76

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated August 19, 2010
  - 45-Charges exceed your contracted/legislated fee arrangement.
  - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
  - Z009-Any reduction is in accordance with the FOCUS Beech Street contract.Explanation of benefits dated September 14, 2010
  - 45-Charges exceed your contracted/legislated fee arrangement.
  - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
  - Z009-Any reduction is in accordance with the FOCUS Beech Street contract.

### **Issues**

1. Was the reduction in payment based upon a contractual agreement supported?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. According to the explanation of benefits, the services in dispute were reduced pursuant to an informal network contract as described by §413.0115. Section §413.011(d-3) states that the division may request copies of each contract under which fee are being paid and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On October 24, 2011, the division requested a copy of the contract between the network and the health care provider, and documentation to support that the requestor was notified in accordance with 28 Texas Administrative Code §133.4. The respondent states in the November 2, 2011 supplemental position summary that "the PPO contract was not valid for this date of service." Consequently, the carrier is required to pay fees in accordance with 28 Texas Administrative Code §134.203 for the services in this dispute.
2. Division rule at 28 TAC §134.203(a)(5), titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual

percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77478, which is located in Fort Bend County.

The MAR for CPT code 99214 in Fort Bend County is \$143.74 (WC Conv 54.32/Medicare Conversion 36.8729 X \$97.57 participating amount). The respondent paid \$117.65. The difference between the MAR and amount paid is \$26.09. The requestor is seeking additional reimbursement of \$20.76; this amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$20.76.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$20.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	<u>2/29/2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**